# Standing Committee on Health Care

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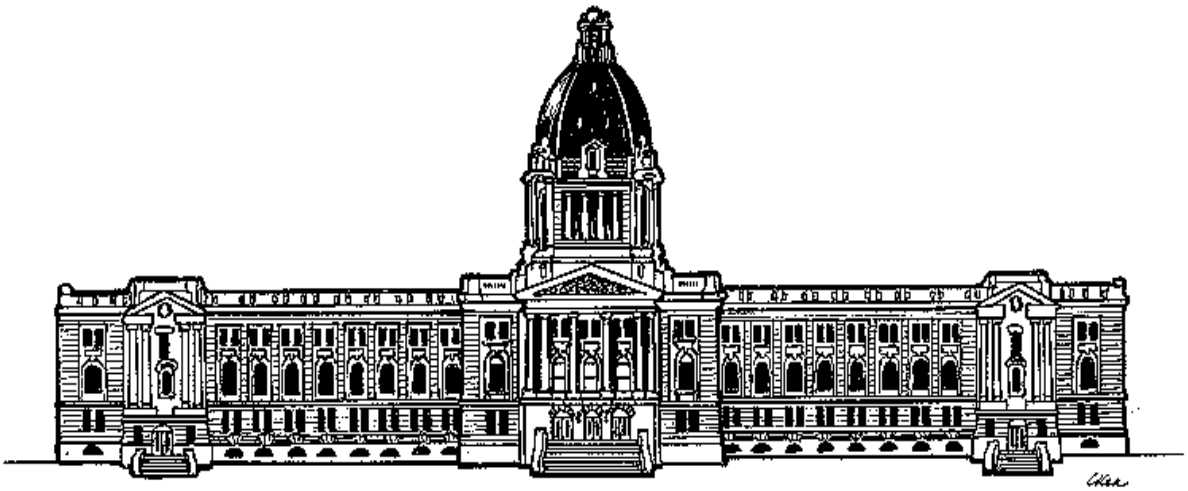

## Legislative Assembly of Saskatchewan

**Twenty-fourth Legislature**

**STANDING COMMITTEE ON HEALTH CARE**
**2001**

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Saskatoon Eastview

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Published under the authority of The Honourable P. Myron Kowalsky, Speaker

The committee met at 10:35.

**The Chair**: — Good morning. I'm Judy Junor and I'm the Chair of the Standing Committee on Health Care. This is a committee of the Legislative Assembly that was appointed by the Legislative Assembly and its first order of business, the direction we have, was to receive responses to the Fyke Commission. And it's an all-party committee and the other members of the committee are Dr. Melenchuk as the Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Donna Harpauer, Bill Boyd, and Rod Gantefoer.

For each of the presenters we've assigned 30 minutes. We usually have in that 30 minutes your presentation and then some time for questions at the end. So if you want to introduce yourselves and then you can begin. Thanks.

**Mr. Fox**: — I'm Tim Fox and administrator of the RM (rural municipality) of Craik in Craik.

**Mr. Haugerud**: — My name is Rod Haugerud, and I'm the mayor of Craik.

**Mr. Leitch**: — I'm Don Leitch. I'm Chair of the Mid-Lakes Community Coalition, and I also am elected for ward 2 of the Moose Jaw-Thunder Creek District Health Board. And I'm Chair of the finance and ethics committees there.

**Ms. Eade**: — Shirley Eade. I'm the administrator from the town of Craik.

**The Chair**: — Thank you. Go ahead.

**Mr. Haugerud**: — Madam Chairperson, honoured members, we're very happy to be here today and to present before you. I'd like to begin by going over . . . just reading the executive summary of our proposal, if that's okay.

This paper explains the ramifications of the Fyke report from the perspective of Craik and district, but also from the wider perspective of the Craik and Davidson access. This paper was prepared by the RM and town of Craik in conjunction with the Moose Jaw-Thunder Creek Health District, but again reviewed by our peers in the mid-lakes health district and also the town of Davidson.

The Fyke report includes some excellent considerations for the delivery of health care to the citizens of Saskatchewan. Mr. Fyke's inverted pyramid is a wonderful reminder that the essential nature of primary care . . . the essential nature of primary care as the most valuable part of the interrelationship of patients and medical practitioners.

It has been suggested that Mr. Fyke was influenced by a similar study done two years ago in Australia since many of the conclusions are similar. This leads the creators of this document to the conclusion that health care problems in democracies around the world are almost identical.

Where the Fyke report differs from the Australian equivalent is in the treatment of health care delivery to the rural areas. By limiting the number of delivery points, as Mr. Fyke suggests, it would appear that in fact there will be a diminished level of service accessibility over the vast reaches of this province. The Australian model increases the accessibility in the rurals.

If one were to be brutally faithful to Fyke, Craik, and perhaps even Davidson, would totally disappear as health care delivery points. The result of such a move would be disastrous to the province given the unique nature of the geography and the availability of health care to this large portion of Saskatchewan.

This paper is revolutionary. It does not propose that Craig and Davidson frantically clutch their facilities each to themselves even though they are historically competitive, and in fact are in two different health districts. They are willing to propose intensifying the collaboration . . . collaborative relationship that already exists between the two physicians. Mr. Fyke has made it clear that a solo practice is obsolete.

This paper shows that although at a first glance one would think that there are two separate practices here, in fact there is a mutual relationship between the physicians that clearly meets Mr. Fyke's recommendations, and in fact, could be a model for other towns in the province.

Retention of the laboratory services at Craik and Davidson are essential since doctors will not practise without these facilities.

Of crucial consideration for the standing committee is the possibility that if these two practitioners were to leave, there would be no medical facilities along the entire 257- kilometre stretch between Regina and Saskatoon — the most heavily travelled highway in the province with a population base of thousands of people.

This paper provides a clear strategy to meet the needs of health care in this substantial area of Saskatchewan.

At this time I'd like to turn it over to Don Leitch to go into it a little further.

**Mr. Leitch**: — When I was asked to take part in this, it was first of all as Chair of the Mid-Lakes Community Coalition. You'll be familiar with the fact that we've had some success in bringing together the communities between Regina and Saskatoon in collaborative efforts of various kinds, not the latest of which this court has to our gratitude elected to name No. 11 Highway as the Louis Riel Trail. We worked on that project for a number of years, and in that process managed to pull together all the towns and villages and RMs along the way — with an eagerness, actually — to recognize this important part of our history.

We have carried that collaborative effort into other areas. You may or may not be familiar with our multi-community collaboration which appeared in this document which is published by the RCMP (Royal Canadian Mounted Police). They were proposing to move the detachment from Craik to Davidson because they were only looking at town size and they had to upgrade their facilities.

We were successful in getting the RCMP to look at a collaborative effort. We brought together 16 RMs, towns, and

villages; put together a committee that studied their proposal; and that committee, including people from the town of Davidson, agreed unanimously that the RCMP detachment should stay at Craik because that's the most logical place to have it.

We have success in bringing together as communities that have previously been highly competitive in joint efforts. And we have continued this further now as this challenge to our health care situation looms before us.

At a meeting with our peers and the CEO (chief executive officer) of the Midwest Health District last week, we got a clear go-ahead from Davidson to bring their name into this. They will be also presenting hopefully later on to this body and to this court.

A little bit of history on Craik because we're going to be taking it from here on in from the perspective of Craik, with the backing of the folks from Davidson.

Craik has a long history of medical care. Since 1904 there's been a doctor in that province. Some of the doctors that have served there served as long as 43 years without leaving that area.

It has become a medical destination for a large area of Saskatchewan — that sort of thing that the retailers are always looking for to become a destination rather than a drop-by place. Craik is a medical destination just because of the long-term nature of its provision of health care.

It in fact had a semi-socialized system of health care as early as 1923. We've talked to 80-year-olds who have never known when they were not protected by health care system within their government — have been under medicare since 1923.

The facility has served many towns. Our doctors have travelled to outpoints, to Bethune and to Holdfast where they held clinics for many years and referred them back to the long-term care and the acute care facility in Craik.

Craik has gone through a number of adjustments over the years and was studied not too long ago by HSURC (Health Services Utilization and Research Commission) as one of the few communities in Saskatchewan that adapted to the changes in the health care without a lot of angst and upset, and they came to find out why.

One of the older folks who was involved in the time that we lost our hospital said when it looked like we had to change, we allowed ourselves one day to grieve, and then we got about the business of reformulating and deciding where we could go from there.

We're understandably going through the same kind of a process now because we understand, as we read the Fyke report, that a community of our size if we were to be looked at only in terms of the number of people who live there, that community would disappear entirely as a health care provider. But we can show you that along with Davidson we provide an essential service to that entire distance between Regina and Saskatoon.

I think probably this would be a good time to ask you to flip through to the index at the back, just so you know what we're talking about. Can you find the, first of all, the map that shows the circle in orange. This is the area as we discovered, as we started to prepare this report, this is the area covered by the physician in Craik. If you were to do Davidson, you could lay another circle that reaches farther north, almost up to Dundurn, and these two circles interlap.

Craik is a town of 453 people, and there are only 300 people living in the RM of Craik, so around 800 people in our area. Our doctor has an active patient list of 3,200 patients. And if you look at that circle in your map and look at where Saskatoon and Regina are, you'll see why.

If you turn to the next page, you'll see the rural municipalities involved. And at our meeting with the Davidson people, they said their map would look similar, only it would extend farther north and farther to the east. So we have interlocking areas there. This gives you an idea of the area that we're talking about.

So where do these 3,200 people come from? If you turn now to the coloured, the coloured patient origin Craik physician diagram in appendix 1, you'll see the breakdown in terms of all the communities that are served by the Craik physician. This is where the 3,200 people come from — 39 per cent come from Davidson, give Davidson as their mailing address; 32 per cent give Craik as their mailing address; the other percentages for the other towns reads like a who's who list of No. 11 and No. 2 Highway. If you turn to the next page with the spike, you'll see again another representation of that, with the actual number of patients adding up to 3,200.

Incidentally, when we prepared this, the folks that work for the doctor in our clinic actually came up with over 3,800 people, but they were rigorous in paring out the people that this committee might question as being people that maybe are double doctoring or having, you know, long-term . . . haven't been really around the doctor's office for a while. So we have 3,200 active people appearing.

Clearly we fall outside of anything that we can find in the Fyke report. On page 22 in Fyke we seemed to find ourselves at first when he was talking about the primary care services. But then we went to the inverted triangle, and we find out that a lot of things that are happening both in Craik and Davidson appear in the second section of his triangle, and that's the part that has to do with hospitals.

We're not a hospital but we're providing primary care of a first-class order so we kind of think of ourselves as being an enriched primary care facility. We have pictures here. Perhaps some of you are quite familiar with our area. Our facility was dedicated . . . (inaudible interjection) . . . Maybe you could pass them on to each side, Shirley. Our facility in Craik is state of the art and was dedicated in 1992. It had been under construction for . . . through two jurisdictions of this House and had its kickoff in 1992.

As we said, geographically, Craik and Davidson are the only two health care facilities between Regina and Saskatoon on Louis Riel Trail. And besides the town of Davidson, these are

the only health care facilities between two lakes — Last Mountain Lake and Lake Diefenbaker — and Regina and Saskatoon. If we should happen to lose our services there, there will be a huge hole in Saskatchewan.

Now let's have another look at this. These are population areas served by facilities in Saskatchewan that have been worked out. Shirley, just pull out Craik and Davidson. Now that's the highway between Regina and Saskatoon — if you just point where they are, please. There's Regina. There's Saskatoon.

We have Imperial on the east side and Central Butte on the other side. And outside of that, in that area, I think around 7,000 people live. Those are the only two health facilities. And we can't find ourselves anywhere in Craik . . . in Fyke.

In addition to that, the corridor between Saskatoon and Regina is by actual count the most heavily trafficked highway in Saskatchewan. The latest numbers that are two years old: 4,200 vehicles travel along that highway every day; a high of 7,000 in peak periods, a low of 2,000, but an average of 4,200 every day of which three-quarters are private passenger cars and one-quarter are truck transports, including all kinds of dangerous goods that are transported up and down that highway.

We have a very active first responders in Craik. I'm sitting beside one of them right here, our mayor. Craik is a typical town. He's also an entrepreneur. He and his father own a short-end manufacturing plant in Craik but he's also the mayor, the chief of police. We do a lot of jobs here. But Rod is an active member of the first responders and Shirley's husband is as well.

And they won first prize this year for being the best first responders in Saskatchewan. That's not without reason. They spend a lot of time mopping up blood on No. 11 Highway and they've had a lot of very difficult first-person experiences, not the least of which was a serious bicycle accident the day before yesterday. That happens all the time on the highway.

We've had some humorous things happen. Years ago, the deputy minister of Health in this province seriously wanted to close down the Craik hospital until he himself had an accident and woke up finding himself in the Craik hospital staring up at the face of our curmudgeonly Irish doctor who was smiling down at him and said well, Dr. Skoll, welcome to Craik. We've had a few experiences like that that are worthwhile along the way.

We would like to comment on a few of the other aspects of Fyke. We've focused on what it could mean to us. But in a wider sense we do support a lot of the things that we find in the Fyke program. We would see value in fewer health districts. I keep looking at . . . in some way — not I would think to the extent that Fyke has proposed — but I keep looking in wonderment at Rolling Hills and Swift Current for instance, you know two health districts that have their offices down the street from each other in Swift Current and you wonder why that would be. So there would be some sense in reducing some of those.

Moose Jaw-Thunder Creek and South Country work together regularly on projects as it is.

I think there are a lot of those, sort of acclimatizations that have taken place over the years that would make a few fewer health districts more sensible. But the 9 and 11 models that we find in Craik, we find — just from our own perspective, living in the country, knowing how far it is to drive between places — we think would be unwieldy and unworkable if you're going to continue with health district boards.

I'm not sure what kind of intelligence you're going to find around board tables if people have to drive five hours to get to the meeting of the health district. And in some of the formats, especially the one that involves Moose Jaw-Thunder Creek — and this is just my own personal observation — we have a presbytery in our church that has just recently put itself together. It's almost those identical lines. And they find they've become almost dysfunctional because of the distances they have to travel.

How are we doing for time, Chair?

**The Chair**: — About 10 minutes and we would like to ask . . . I think a few people might want to have a question or two.

**Mr. Leitch**: — In the back page, back pages by the way, one of the big things that we really support in Fyke is the Telehealth centre. Now, Mr. Gantefoer, you know that we were off and running on that a long time ago. Moose Jaw-Thunder Creek actually started talking about a health centre . . . a Telehealth centre about four years. And of course Craik, not to be outdone, suggested that we're in an age when we're trying to decentralize things from the large communities to the smaller ones, why not have the Telehealth centre in Craik?

So this gang got together and they put together a proposal which we left with government and with the opposition, with the Health critic. They're quite familiar with the fact that Craik would be of course the logical place for the situation of a Telehealth centre because it would fit . . . we're right along the proper delivery lines of information. We've got the information systems going right by the edge of town. And we could provide all the wonderful living arrangements for people within easy distance of the two largest cities and the third-largest city in Saskatchewan.

We think that removal of facilities from our area as they exist would provide a great handicap to the older people and people without regular forms of transportation to travel all the way . . . It would mean the only available health care that they would have would be in Regina, Saskatoon, or Moose Jaw, which are really for older people and people without transportation just really impossible travel arrangements.

We think health would suffer as a result. People would leave undone the kind of medical approaches that they really should be making to doctors and would only appear then when they were in a chronic and critical stage. And as you know that's when it becomes very expensive for the system.

I guess we would leave the paper with you folks to work through. We'd maybe conclude with the conclusion, which I'll read, and then we'll be open to questions.

Some observations. I'd like to draw your attention to that.

We think that health boards should be elected and appoint officials who are accountable for budget deficits. Moose Jaw-Thunder Creek Health District has balanced its budgets every year, and we believe this is possible for all health districts who seriously undertake proper stewardship.

We don't think that employees of health districts should be elected or appointed to serve on the boards and we support the implementation of electronic health records.

While we recognize the government's intention and Fyke's attempts to change health care delivery systems in this province to the benefit of everyone, we feel that not enough thought went into the ramifications of his proposals, especially in the rural areas.

We applaud Fyke's inverted pyramid and his recognition of the essential nature of primary care as the best results for the dollars spent. We would, however, urge the standing committee to widen the rather narrow idea of primary care that Fyke presents.

We believe that Craik and Davidson are offering an enriched level of primary care to a huge area of this province and that the results are easily measurable in patient satisfaction and quality of primary health delivery.

We recognize and sympathize with the many communities that will be presenting to this committee and requesting no change in their health care delivery status. But we're presenting a different idea.

We are describing two communities and two different health districts who have traditionally competed with one another at every level. These two communities are joining in recognizing one another's strengths and proposing to continue the collaborative efforts already begun in sharing of physicians' services. We believe we can, at minimal cost to the Government of Saskatchewan, provide outstanding primary care to a huge area of this province and urge this committee to support us in our endeavour.

And in conclusion, I'd just like to say I met with our doctor this morning before I left and she's been in intense conversation with the physician in Davidson. I asked her . . . we asked her, in this group last week, how she would feel if we diminished our services in Craik at all. And she said, well, if you're talking about, for instance, my lab —if it goes, I go.

And the Davidson doctor with whom she collaborates at every level . . . they work out of each other's pockets all the time, so they're covering over for each other. In a sense it's a dual practice even though it's 19 miles apart.

The Craik . . . the Davidson doctor said, if she goes, I go. So a domino effect could take place very quickly in our area. All you would have to do is pull our lab and we would lose two doctors, and suddenly there would be no medical care between Regina and Saskatoon.

**The Chair**: — Thank you. Mr. Gantefoer.

**Mr. Gantefoer**: — Thank you, and thanks to all of you for coming this morning.

A couple of questions. One surrounding the idea of two communities willing to work to even a greater extent in collaborative practice. And you mentioned that these two communities are in two different health districts. When you're talking about the reorganizing of districts, would it be useful for that collaborative practice if both communities were in one district or in a shared district?

**Mr. Leitch**: — I would think that we would find that more useful. But we've found that we can work together . . . Like we've been feeling our way through this, Mr. Gantefoer. The docs are quite content as long as they have the facility to refer back and forth as they have now. Folks from Craik end up in the acute care beds in Davidson on a regular basis. Their doctor is down at Craik whenever our doctor is away. There's been a very easy development of that relationship. I'm sure that technically it would be better if we're in the same health district.

**Mr. Gantefoer**: — You mentioned in your submission that both facilities are fairly well equipped and fairly modern. Perhaps issues of equipment replacement, capital programs, etc., might be more difficult under two separate jurisdictions than they might be if they would be under a combined vision and planning process.

If it doesn't make sense to have two, or one health district, is there the possibility of a model that would allow for, you know, collaborative processes and communications so that capital projects and things of that nature between the two as a collaborative practice, if you like, could be streamlined?

**Mr. Leitch**: — We discussed that with the folks in Davidson last week. My sense was that they felt since we're feeling our way into the collaborative relationship right now, Mr. Gantefoer, that they would . . . both sides, I think, would be open to whatever developed down the line. We know that capital equipment replacement is really essential these days in provision of good health care. We couldn't see anything at this moment, because both of them are so well equipped, that either one of those facilities really would need at this moment. We are aware of the fact that three or four years down the road, we would probably have to consider seriously . . . you know, we wouldn't want to be duplicating each other's efforts all the time.

Would you like to comment on that, Rod, because you were in on that discussion.

**Mr. Haugerud**: — Yes. As Don has said, this is very preliminary in our discussions with Davidson, and so capital expenditures and that haven't got discussed yet. Right now, as Don has said, that both facilities are well staffed and equipment is pretty well new; that as we went along, these would rise, I'm sure, and we would deal with them.

We've proven in the past that, you know, that we can work together with other communities. And like he said, with multi-community collaboration on the RCMP, you know, that was a feeling our way through the dark too. And now we have that model to go by, and then people already established as

contacts, so we are a few steps ahead already on that effort.

**Mr. Gantefoer**: — Finally, I certainly want to congratulate the community of Craik on their proposal for Telehealth centre back in '98, and certainly to see that recommendation included in Fyke and also being implemented across this country is a testimony to your foresightedness, so thank you very much.

**The Chair**: — Thank you.

**Mr. Thomson**: — Madam Chair, actually Mr. Gantefoer pursued the line of questioning I was interested in, so I will pass.

**Hon. Mr. Melenchuk**: — I have a couple of quick questions. First off, thank you for your well-researched demographics, especially with regard to your drawing area. That's very useful information.

And also with regard to the layout— I like the way that you actually critiqued Fyke and put forward your suggestions as it related to your primary care service area, which is again nicely done.

The question I have is in terms of the approach that you would have with expanding your enriched primary care centre. Do you see a role for advanced clinical nurses, a team approach that maybe involved pharmacists where there were sharing of patient information or perhaps charts?

I know that you are in favour of an electronic health record. But having more practitioners having access to a patient file, how would you see that fitting into your primary care service area?

**Mr. Leitch**: — Yes, we've discussed that at some length, Mr. Melenchuk. And if we saw primary care nurses as replacing the two physicians that we have, we thought that that would be a step backwards. But if we saw primary care nurses as an enrichment to what's happening already, we see a wonderful collegial relationship developing, you know, with the two docs to back everybody up. It would take a lot of the pressure off them.

Really when you think about the kind of responsibility they're carrying, for a really large portion of Saskatchewan, between two people, they don't get real time to be humans, you know, in a lot of ways. So I would see an enrichment of what they're doing already, and I think the primary care nurses would fit right into that area.

**Mr. Haugerud**: — I think maybe what is . . . one of the things that wasn't mentioned is both of our doctors are young. Our doctor is 30 years old; came from South Africa and married a local fellow. So we're looking for a long-term commitment from her. And so this is . . . we're not . . . we're not one of them communities that has been jumping from doctor to doctor every year or two, you know. She has been there now . . . five years, five years, you know. So she has become part of our community, and feels as Craik is home too, you know. And the doctor in Davidson also is in his young 30s.

**Mr. Leitch**: — In fact when we get asked what's the first step we should take in keeping our doctor, we always respond, well, shop at the co-op. Because her husband runs the lumber yard there, right. As long as you buy locally, he's going to be interested in staying around. And as long as he's interested in staying around, you know, love has its way. And they've just recently had a child and she's very happy to be in this community. But if we take her lab, she's going.

And I understand that . . . Dr. Melenchuk, you would understand that.

**Hon. Mr. Melenchuk**: — Well absolutely. I have one other question, and in terms of some of these suggestions from Mr. Fyke with regard to alternate payments for physicians in primary care settings, has there been any discussion with the physicians in your area in terms of their receptivity to say a straight contract with their district as opposed to fee-for-service or some other alternate form of payment?

**Mr. Haugerud**: — No, we haven't had any discussion with our doctors on that topic. In the past it was on a contract basis. As Mr. Leitch pointed out earlier that we have had a medicare program since 1923 and our doctors were contracted at that time. So I mean we do have a model to go by but no, we have not had any discussion with our physicians at this time.

**The Chair**: — Thank you. I'd like to thank all of you for your presentation and for your handouts that you gave us. Also thank you for the picture. We are going to keep it and we said, yes, that's very nice. And thank you again for coming.

I would ask the midwives to just come and take a chair at the table.

Good morning. I'm Judy Junor. I'm Chair of the Standing Committee on Health Care. The Standing Committee on Health Care is a committee of the Legislative Assembly and it's an all-party committee. The other members of the committee are Dr. Melenchuk as the Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Donna Harpauer, Bill Boyd, and Rod Gantefoer.

The Legislative Assembly gave us direction to receive responses to the Fyke report and that's what we're doing with these hearings. We've set aside 30 minutes for your presentation, as well as some time within that 30 minutes for us to ask . . . for the members of the committee to ask a few questions. So if you want to introduce yourselves and then you can begin.

**Ms. MacKenzie**: — My name is Eileen MacKenzie and I'm president of the Midwives Association of Saskatchewan.

**Ms. Breitkreuz**: — My name is Lorna Breitkreuz. I'm a midwife that's registered in Manitoba or registerable in Manitoba.

**The Chair**: — You might have to just speak a little closer to the mike.

**Ms. Breitkreuz**: — My name is Lorna Breitkreuz and I'm a midwife that's been registered . . . is eligible for registration in Manitoba. I live in Saskatchewan.

**Ms. Ellis**: — Cathy Ellis. I'm from Regina. I'm a midwife here and a nurse, and I've just come back from five months teaching midwifery in Kosovo.

**Ms. Wurz**: — My name is Esther Wurz. I am with the Hutterite communities and I'm a member of the midwifery association of Saskatchewan.

**Ms. MacKenzie**: — I might also add that I'm a practising midwife here, registered in Britain but not in Saskatchewan.

On the brief that I've given you I have outlined the role of the midwife so I don't think that I have to reiterate that. This will come across sort of as I'm reading here.

Just to give you a little historical review of what was happening in the past. At the beginning of the 20th century, midwifery in North America was just about eliminated — in fact it was eliminated. I think the last midwife who was sort of recognized at all was in Manitoba in the '40s. And because of this there's been a lot of myth and misinformation over the years about midwifery to the point where some people regard midwifery as second-class obstetrics for those who cannot get a doctor. This is particularly prevalent among the First Nations, as I found out when I spoke to the kohkoms.

In Saskatchewan in the '80s, maybe as a result of the '60s revolution, women started to think more about their own health. They were disenchanted with the care they were receiving to have their babies and they started looking about for people who felt the same way and who would catch their babies.

As a response to this, a few of us felt that conditions were not safe and we started the Midwives Association of Saskatchewan so that we could standardize care, and ultimately bring legislation to bear that we would be an autonomous profession in Saskatchewan.

Those ladies who belong to SASAK (Saskatchewan Association for Safe Alternatives in Childbirth) are still around. There are more women joining all the time; they are now called the Friends of the Midwives.

In 1985, the Midwifery Advisory Council presented a brief to the government to suggest that an implementation committee be drawn up to see the feasibility of midwifery. And this was done, and they worked for nearly two years and came up with us — we presented them with our standards, bylaws, etc. and on May 5, 1999 — The Midwifery Act was passed in the legislature. We were declared an autonomous profession.

But the Act has not been proclaimed, and so midwives are currently practising still unregulated and uninsured. We cannot be insured in this province until we are regulated and this hasn't been done yet.

One of the reasons was because . . . one of the reasons probably was because there weren't enough midwives and no funding was put in place to send midwives out of the province to be assessed in other provinces — British Columbia, Ontario, and Manitoba in point.

In the spring of 2000 the Minister of Health, then Pat Atkinson, promised the midwifery association that a person would be hired to set up a midwifery pilot project with three midwives and these midwives would come from other parts of Canada.

So that's the way we are now. The project was put on hold because we changed our Premier and we changed our Health minister. So we really don't know whether that's going to happen at all.

But what I haven't put down here was the latest thing I heard from Dianne Anderson, who's a member of Sask Health, that the Solicitor General is looking into joining us with Manitoba with their regulatory body, their college, so that we can take their exams and have our program with theirs.

In Canada we have five provinces that have registered midwives with hospital privileges — Ontario, Quebec, British Columbia, Manitoba, and Alberta. Alberta doesn't have any funding. The others all do. They are part of their medical care package.

And I put here to be noted that Saskatchewan is the only province in Western Canada without regulated midwifery, yet we were the first to bring in medicare. And I think this is very, very important because we really are lagging behind here.

There is a program being set up — a baccalaureate program — being set up in British Columbia, University of British Columbia. Manitoba hopes to have theirs set up somewhere in Manitoba in the next year. Ontario has three universities where programs are going on and they have graduated over 200 midwives.

Ontario has 221 registered midwives. British Columbia has 67 registered but only 61 practising. Manitoba has 27 practising midwives and they are still . . . still more are coming. So there are 398 regulated and non-regulated midwives in Canada. In Saskatchewan we have one midwife registered in Manitoba.

And when I say this, you must realize that the Canadian midwifery model is all the same. There is now reciprocity across Canada, so what applies to one province applies to all these provinces — apart from the funding of course, which is up to the provincial governments.

So we have Lorna registered in Manitoba; we have Cathy, who's done her exams in British Columbia but hasn't yet fulfilled her clinical requirements; and three of us who are registered in Europe who have been practising here in an unregistered state; and Esther.

In other countries, 70 per cent of the women have midwives as their primary caregivers. Midwives are regarded as safe — if not safer than doctors — in low-risk situations. The use of midwives significantly reduces the rate of unnecessary interventions and therefore makes it more cost-effective.

Midwives have success in reaching socially disadvantaged groups. I'm thinking in our case of the . . . of people of First Nations.

Women have more satisfaction with midwife-managed care as it leads to a feeling of empowerment. And this again is

particularly important with the First Nations women, because at the moment they don't feel empowered at all.

So where do we fit in with the Fyke Commission? I'd like to read you this little extract from Marsden Wagner, a very wise man, who I think hit the nail on the head:

> In those places in the world where autonomous midwives have equal standing with doctors, the combination of the midwifery model with the medical model results in the most modern, optimal maternity care system and the best outcomes for mothers and babies.

Mr. Fyke wants teamwork. We're great team members. We're great collaborative people.

We're an independent profession. We're not under anybody's umbrella — neither the doctors nor the nurses. We know our skills and limitations and don't try to exceed them. We do well in a community health setting.

When Pat Atkinson first suggested that we could have a pilot project, my first thought was the community clinic setting where you have everyone together. You have the physios, the doctors, the nurses, the labs — everybody there together. An office for midwives therefore would make very good sense.

Certainly in England where I'm from, if your low, low, low-risk lady suddenly becomes ill or something crops up with a lab test or something of the sort, we would just phone and say to the doctor and say, would you please . . . I'm sending this lady down to you, will you please look her over.

We are totally . . . I mean when I say low risk, nobody's totally low risk. It has been said that no birth is low risk until it's over. Things can crop up in the process of a birth, but midwives are trained for medical emergencies. We know when to transfer to care but we also know, when we're faced with a situation where care is immediate, has to be done immediately, that we know how to deal with that.

We believe in birth as a normal event in the family, not a disease.

We only look after women. We don't have clinics with people who are sick in other respects to look after, so we're totally women-focused and women appreciate that.

We give continuity of care throughout the pregnancy and I don't mean a 10-minute visit, I mean a visit of 45 minutes to an hour where everything is discussed in the family. The husbands or the partners are there frequently, other children in the family. We examine the mother, the fetus to check up and see that everything's okay. We listen to everybody's concerns, both emotional and physical.

So we have a pretty holistic idea of what's going on in that family. Because it's not always apparent; people don't always tell you right off the bat, or you can't sense that something's wrong. But it's pretty easy — well it's not easy but it is . . . one can sense when there's a relationship problem between the husband and wife and there's a kind of a problem in the family.

If the women choose to birth at home — and we're thinking of cost here — the cost to the medical care system is certainly lower because the woman never goes into the hospital.

If you're thinking of fragmentation, and this was something that came up in the Fyke report, the women's care at the moment is fragmented because the women who choose midwives when they go into the hospital, because we don't have hospital privileges as registered midwives, they go in with the midwife who stay there all through the labour, but the birth is actually done by the doctor. This is fragmented care.

The midwife will see the doctor perhaps just for the birth of the baby and then the doctor's out again. We look after the woman then for six weeks, and the family doctor is there to pick up where we've left off.

There is an impending crisis in medical care in Canada. The general practitioners are leaving obstetrics because of high insurance cost. I think you've lost quite a few in Regina and obstetricians are taking up the slack. This means that your cost, the cost to the medical system, are higher because obstetricians of course charge more than general practitioners do.

Obstetricians are also looking at the disease process where no disease exists. So it's rather like hitting a fly with a hammer. Certainly midwives, as GPs (general practitioners) do, call on obstetricians if there's a need to do so, if there is a disease process going on. Midwives of course also recognize the fact before the disease gets to the point where there could be an emergency situation.

Why do women choose midwives? They want to be accountable for their own health and that of the family. And this is a good thing, because now we need people to be accountable for their own health. They have to be.

They can't just go along thinking that medicare . . . this is one of the disadvantages, perhaps, of medicare that we have lulled people into a sense of security. They don't have to look after themselves; they just have to go to the doctor and they'll be given a pill. They've got to be more responsible for their own health and more accountable. And these are the women that phone us up and ask for our care.

There are more women asking for our care than there are midwives to look after them. We look after women from all over the province, from La Ronge — that's the highest we've been — to Rose Valley, to Swift Current, to Regina. A couple of them in Rosetown. We don't have midwives anywhere else except Springside, Regina, and Saskatoon. The women are quite upset about that and need more midwives.

The women want to choose their caregiver and their place of birth since 85 per cent of the women are low risk, in the low-risk category. They want to be educated in birth procedures and prepared for breast-feeding. This is something that we do. This allows them to be informed when they're asked for consent in the hospital, for example. If they're asked for something that they don't quite know about, perhaps things aren't going very quickly, they then like to consult with us. And they're assured that we have a research base.

We are associated with the Canadian . . . We are part of the Canadian Association of Midwives which in turn is associated with the International Confederation of Midwives. So we have a large database to rely on for research.

As far as home birth is concerned, the Canadian Association of Midwives has put out a position statement on that which I can give you. We had a meeting with Marsh Canada who are the people who insure midwives across Canada, at least insure everybody now except British Columbia. Their government does that for them. And when they were asked if they felt that home birth was less . . . was more risky than having a hospital birth, they said no, that everybody was charged accordingly, was charged the same amount of insurance whether they did births at home or in the hospital.

Midwives are also associated with La Leche League. This is a breast-feeding group. Breast-feeding babies early has been proved to give good habits later on. And also of course with the women being more accountable for their families and themselves, they are looking after the nutrition of their families which again is good for our medical care system. It promotes healthy lifestyle choices.

They are looking for alternatives to birthing in hospital, either at home or in a birthing centre. Many, many women that we've spoken to would prefer a birthing centre. And this is again where the community clinic set-up comes in. They're not really . . . Perhaps 1 or 2 per cent would like a home birth but the birthing centre seems to be more popular. It doesn't have to be a community clinic setting. It could be a house.

In Calgary they've set up birthing centres — in Calgary and Edmonton —where there are houses which are converted. These places are very close to freeways so that they can get on to the system and get into the hospital if there's an emergency.

As I said, more women are demanding our care than we can provide. We're cost-effective once the system is set up. Ontario midwives are finding that the number of home births increases, the longer the midwife is established in the community.

I was listening to the gentlemen from Craik and Davidson. The situation there is that you could have a midwife in that collaborative setting with the doctors, the nurses, the labs, and the physios. That kind of community setting would suit midwifery very well, and it would take the pressure off the doctors. It would take the pressure off the nurses, and the pharmacists. We make good team members.

We would be very good, as I said, for the First Nations, especially if we could get the First Nations women to train as midwives because they could use not only their native skills or their traditional skills but also ours as well.

And finally I would like to remind Mrs. Junor of . . . at the bottom here, I've made . . . the statement that she made — the impact of integrating a new group into an already changing system has to be considered. And this was concerning the costs of setting up the system.

We would not have a training school here in Saskatchewan. If we were regulated with Manitoba we would use their facilities. But the midwives who were registered there, who did their examinations there would come back to Saskatchewan where midwives would be able to act as their preceptors in practice. And in that way we would get midwives all over the province.

Midwives are willing to travel. Their husbands we found are also very willing to go too, to places outside big urban centres, which is very important.

With all the changes that are proposed in the Fyke report, I think that we belong there now. I think that our time has come, especially in view of the fact that we were promised a project.

**The Chair**: — Thank you. Is that the end of your presentation? Mr. Belanger.

**Hon. Mr. Belanger**: — Yes, just a couple of questions here. Excuse my voice, I'm fighting a cold here.

A couple of things and I'll point out first before my question. Annie Johnstone is in the Saskatchewan Order of Merit, having I guess been a midwife in northern Saskatchewan where my home is.

The question I have is: would you say that being a midwife or having your child being delivered by a midwife is more of a perception problem in the general public, because . . .

**Ms. MacKenzie**: — No, it's not. One of the things that's happening here is that because in Saskatoon — and I can't speak for Regina — we only have one hospital now where babies are being delivered, a great number of babies are being delivered, and the women are finding that they're subject to a great number of interventions.

Now whether this is because . . . Especially the younger women. They're finding, when they go into the hospital — they don't know when to go, so they go very early — they go into the assessment unit and they're asked if they want to have an epidural.

This never used to be the case. It was always that women were told, well if you feel that you need an epidural or you need pain relief, you ask us. The opposite is being said now. They're being asked when they want to have the epidural.

And one of the things that has been found, and certainly in England, that the lower the education of the person, the more likely they are to ask for interventions, the more likely it is that they have not done much research into what's available for them.

Midwives tend to use other approaches, many other approaches. When we're with women, we keep them at home. We use water. We use bathing. We use massage, relaxation techniques. In some cases we encourage them to use hypnotism. Practitioners of . . . they're sort of self-hypnosis. Some women use chiropractors. But they're open to . . . when they're with midwives, they're open to all the other people who could help them so that they don't have to have drugs.

The people who come to us do not want drugs. And they feel, when they go into the hospital, that they lose their freedom.

And they use us as advocates, really; keep me safe while I'm there.

Well I mean I don't need to pull down the hospitals. They do terrific jobs, and those nurses there certainly do. But the nurses are busy. When we go into the hospital, the nurses are usually very pleased to see us because it means that we can just get on with it and call them when we need them.

**Hon. Mr. Belanger**: — My second question is: it's noted here that in Germany, Holland, and some of the other countries, that 70 per cent of the births are being done by midwives, and yet Canada has been noted as being one of the best countries in the world to live in.

What kind of success . . . what are some of the things that you're doing in some of the countries where the rate by birth by the midwives is much greater than Canada's?

**Ms. MacKenzie**: — Sorry, I lost that last bit. I couldn't hear you properly.

**Hon. Mr. Belanger**: — I guess some of the countries that you've noted here, you've said that 70 per cent of the births are being done by the midwives. And yet Canada as a whole, by the UN (United Nations), they're considered one of the better countries in the world and some of that of course is because of the health care system.

So my question to you is: in the countries where we have 70 per cent of the births by the midwives, what are they doing different than Canada?

**Ms. Ellis**: — I can respond to that question because I just spent the last five months teaching midwifery in Europe, in actually the biggest hospital in Europe, in Kosovo where they had 40 deliveries a day. But many of my colleagues were European midwives and physicians, and people just go to a midwife there as a matter of course.

And in fact most of the . . . many of the northern European countries where 90 per cent of the births are done by midwives have much better statistics than we do. Now some of that has to do with the woman's nutritional status and just general living conditions and rates of poverty or wealth. But the World Health Organization, whose recommendations we closely followed in Europe, recommends that normal births be taken care of by midwives.

And I find it a little bit odd that Canada has been so slow to do that, given that we are a very developed country. And this province, as Eileen has said, is going to be one of the last.

And the main obstacle I see in getting good care, good personalized care for women in our province, would be getting enough midwives because there just haven't been very many educational programs across Canada. But now that there's going to be another one set up in Manitoba and BC (British Columbia), we have the possibility to get on board, get young women trained as midwives and within a couple of decades get midwifery care as a choice for women in Saskatchewan.

And they're certainly asking for it. There's no way that we can meet the demand. We just don't have enough midwives here. We get phone calls all the time from women around the province.

**Ms. MacKenzie**: — I'd also say that Canada and the USA (United States of America) — parts of the USA of course do have midwifery — but Canada and the USA are the only two western industrialized countries that do not have midwives as part of their health care system.

**A Member**: — Well we do now — five provinces.

**Ms. MacKenzie**: — Well we have five provinces, but I mean as a whole, Canada as a whole.

In Britain, where I come from, it is considered that, first of all, the woman does have a choice. She can choose to have a doctor. But most women choose to have midwives and a lot of those women have their babies at home. In all my practice in England, well when I worked in the community of course, I worked . . . we delivered babies at home.

But the midwives who have hospital privileges in Ontario and all these provinces that do have regulated midwifery with hospital privileges, the midwives take the women into the hospital and actually catch the baby there. And then they leave, they go home with the midwife. They do not grace the hospital bed. So that is a cost saving right there.

**Ms. Harpauer**: — Thank you for your presentation. I recognize the importance of midwifery and mothers having the choice of birthing methods that are available to them. But considering the demographics of Saskatchewan, fewer and fewer centres are offering birth. Part of the reason, I understand from physicians, is the insurance is too high because they have too few moms.

So I'm trying to understand. How would you incorporate your profession into the demographics of what we have here in Saskatchewan? If we had a midwife in rural Saskatchewan, she probably wouldn't have full-time work available to her due to lack of births that are happening.

Would you be looking at just establishing your profession in the larger centres, or do you foresee establishing in the teams that would be in rural Saskatchewan? And if so, would the cost savings offset the fact that you would be spending a great deal on transportation costs?

**Ms. MacKenzie**: — I don't think that we will be spending a great deal more money than anybody else on transportation costs.

I could foresee in the future, and certainly it's not in the next five or ten years perhaps — or maybe it is — that midwives will be part of the team. As I say, it takes the pressure off the doctors and the nurses.

There might not be very many women. But on the other hand, you'd be surprised how many there really are. The only fact that you're not seeing more now is because the women are going to have to go into Saskatoon to have their babies.

But I mean if the midwife is part of the team in that community,

as it's been established, women will choose a midwife. If that woman is long established in the community, then I think that we have a place there.

And I don't think it's going to be any more costly, because everybody will be salaried. This is one of the things that Mr. Fyke recommended, a change in the way people bill, etc. And midwives don't bill by the hour, by the way. I mean it's a course of care from the beginning when the woman first comes to when she leaves you, six weeks after the baby's born. And this is how it's been in all the other provinces in Canada.

**Ms. Breitkreuz**: — Yes, I would just like to also add that like currently we are conducting births in rural centres; like where there is no maternity care in that centre. We have standards in place that were developed by the midwifery implementation working group and that are consistent with, for example, Manitoba standards that talk about the distance you know, for conducting birth, and the safety factor, and what has to be in place.

And a lot of those things are in place in this province. So midwives could conceivably span two or three health districts in the care that they provide. And you know, as long as we're working within the guidelines, and we're conducting births . . . like we have been an hour and more away from a centre that provides backup maternity care for us. And that's where, you know, assessing the risk, and discussing the care with the woman, and all of that makes the decision . . . you know, the decision is made jointly and all those risks are taken into consideration.

And so I think midwives would be busy, and I think they would be employed by more than one health district if it was that type of an arrangement that was made. I think that they would be working with probably a couple of different clinics, so to speak. And that's how I can see that happening.

In the area where I work we have three health districts that are very . . . within quite close distance, and I get calls from all of those three areas all the time, as well as far away as Regina and Saskatoon where I've taken on births. So we're looking at two and three hours between . . . you know. And it's . . . as more midwives come onto the system . . . you have to start somewhere, you know. And with the number that we have and the ones that are trained up the way they are right now, they could go right away. And yet, there's no . . . it's really difficult to continue and sustain that when there's no political will, or there has been but it's sort of at a standstill, to continue on.

So, you know, even though we're small in number, you can get a lot of work, and geographically things could . . . you know, you could work those things out.

**The Chair**: — We are fast running out of time. Dr. Melenchuk will wrap up for us.

**Hon. Mr. Melenchuk**: — Thank you very much for your presentation. Just a couple of quick questions.

In terms of your association, what are your recommendations in terms of number of cases per year to qualify as a full-time equivalent? Or even safety issues, what would you see as being the right amount in terms of a year caseload?

**Ms. Breitkreuz**: — I'll speak to that from the Manitoba standards. They recommend 40 births per year as a primary attendant. And then you would be assisting, work as a second midwife for 20 more births. So you're looking at approximately 60 births per year with 40 being a primary attendant for.

**Hon. Mr. Melenchuk**: — Now you're limiting your . . . basically from the time of, I guess, first diagnosis to six weeks postpartum. Do you sometimes assist women, or in consultation after the six weeks say, as lactation consultants, that sort of thing? These aren't hard, fast rules that you're working by.

**Ms. MacKenzie**: — As far as midwives are concerned, it is a hard and fast rule, the six weeks. But as a lactation consultant . . . midwives can also be lactation consultants. And our clients certainly do consult us after the six-week period. But we are not responsible for them as clients after that time. So I mean we're really used as a consultant then.

**Hon. Mr. Melenchuk**: — Last question — well actually second-last question — in terms of remuneration, you would prefer the salaried model as opposed to fee-for-service or some other model.

**Ms. MacKenzie**: — Salary, yes.

**Hon. Mr. Melenchuk**: — And my last question: in terms of the expectation for the amount of cases you would have, looking at the global concept or global amounts in Saskatchewan, what per cent . . . I see that British Columbia is almost 7 or 8 per cent in terms of deliveries and Manitoba's what, 4 or 5 per cent? Would you expect similar numbers here in Saskatchewan — somewhere between 4 and 8 per cent overall?

**Ms. MacKenzie**: — Yes. When . . . I mean Manitoba has only been started up, I mean not too long, so they're already at 4.5. You know it kind of, it goes up according to how long the system has been going. Certainly this is why it's 6.6 in British Columbia and 4.5. So initially I think it would probably be . . . it would start off slowly because of course we don't have the number of midwives. But as more midwives joined the system, you would certainly see more, more women asking for midwifery care.

**The Chair**: — Thank you very much and thank you very much for your presentation. We'll take two minutes while we switch presenters.

**The committee recessed for a period of time.**

**The Chair**: — I think we'll start. We haven't got everybody here but I'm sure they'll come pretty quickly.

I just wanted to make a few opening remarks. I'm Judy Junor, Chair of the Standing Committee on Health Care. This is a committee of the Legislative Assembly, and we have been instructed to receive and report on the responses to the Fyke Commission. We've given everybody about 30 minutes and that has included questions.

And our report is to be back in to the Legislative Assembly by

the August 30. So we're sitting all of July, hopefully, to hear as many people as we can.

So if you want to introduce yourself and then start your presentation.

**Ms. Block**: — Okay. Well thank you for providing us an opportunity to submit our responses to the Commission on Medicare's report.

My name is Kelly Block and I am the chairperson for the Gabriel Springs Health District. And presenting with me today is Gren Smith-Windsor, the chief executive officer of our health district. We had also listed our Vice-Chair as presenting with us, Ms. Kushneryk, and she sends her regrets.

Because our time is limited, we're going to keep our comments in line with the text that you've been presented with. Gren will give you a small snapshot of who we are as a district, and then I will outline the consultation process that we undertook, as well as identify the implications that the recommendations would have for the services we deliver.

**Mr. Smith-Windsor**: — Gabriel Springs Health District has a population of 11,730 people — third smallest of the Saskatchewan health districts in terms of population. The district is a rural farming community, including six towns, five villages and hamlets, two Indian reservations, and a Hutterite colony.

The district is located between Saskatoon and Prince Albert, including the communities of Waldheim and Laird in the west and Wakaw in the east. The district includes the historic Saskatchewan valley sites of Fort Carlton, Batoche, and Fish Creek.

Over the past 11 years the district has experienced a slight population decrease, although the most recent population projections for the area compiled by the Saskatchewan Health Services Utilization and Research Commission point to a modest population growth by the year 2015. The district population is characterized by a larger than average number of senior citizens, a higher than average number of children between birth and age 14 years, and a higher than average number of First Nations people.

Gabriel Springs provides a wide range of health programs and services, including acute and emergency services in Wakaw and Rosthern, home care services, public health and community-based services such as physical therapy, occupational therapy, nutrition services, mental health services, addictions, and family counselling services.

As well the district is affiliated with special care homes providing long-term care in Rosthern, Duck Lake, and Wakaw. The health districts and affiliates employ over 375 people. Seven family physicians practise in two stable medical practices in Rosthern and Wakaw.

Since the beginning of health reform in 1993, the district has reduced institutional beds in some acute care hospitals and special care homes while home- and community-based programs and services have expanded. District programs and services have been fully accredited as the district has participated in the accreditation program offered through the Canadian Council on Health Services Accreditation in 1997 and again in the year 2000.

Although The Health Districts Act specifies that a health district board must be comprised of 12 members, the current Gabriel Springs District Health Board has only 8 members as a result of resignations. Like most other health district boards in the province, the Minister of Health has allowed the number of vacant board positions to remain unfilled.

Gabriel Springs has an operating budget of approximately $11 million. Characteristically the district has operated in the black ink, running a series of balanced or surplus budgets and accumulating a modest operating reserve. Regrettably, this year the government funding has not kept pace with the cost of collective bargaining settlements and other escalating program costs and accordingly the district is faced this year with an estimated deficit of $290,000.

**Ms. Block**: — I'll just move right into describing the consultation process that our district undertook upon receiving Mr. Fyke's report in April of this year. Our board did a comprehensive review of the report and studied the recommendations. And it was obvious in our view that the recommendations would have the greatest impact in rural Saskatchewan.

In order to have a broader understanding of how the implementations of these recommendations would affect the programs and services we deliver in Gabriel Springs, should the government adopt them, consultations with a wide range of service providers as well as the public within our district were undertaken. First we met with the physicians of the district, as well as managers, union representatives, and our staff.

We also formed a community advisory community. Representatives were invited from all town councils, RM councils, the physician groups, First Nations, and the affiliated agency boards as well as our district health board members to form this committee. And based on the discussion that we had at that first community advisory committee, the district held two public meetings in the towns of Wakaw and Rosthern which included all of the surrounding communities.

These consultations resulted in the identification of the following implications in three main areas. And we've basically highlighted the implications and haven't really focused a lot on the things that we would support in the report. The recommendations which we have highlighted are everyday services, specialized services, and in support of change. However, it should be noted that our board supports Mr. Fyke's recommendations that continue to focus on prevention and wellness and our ability to ensure, through provincial standards, the provision of quality services defining where and when they are while considering the need to contain costs within the health care system.

Mr. Fyke is recommending the conversion of many small, existing hospitals into primary health centres as well as creating 10 to 14 regional facilities that would provide acute care to the residents of rural Saskatchewan. It is not clear what criteria

would be used to determine which small hospitals would be converted and where these primary health centres would be located.

If the conversion of acute care centres were to occur as recommended, a number of issues arise in terms of the lack of services being provided in primary health centres. It is our understanding that primary health and community care centres would not be equipped to provide diagnostic services. The ability to provide diagnostic services is critical in any kind of service reconfiguration. Without these services the physician's ability to practise medicine as part of a primary health team would be severely limited. And it is quite clear that it would become increasingly difficult to recruit physicians to rural Saskatchewan under this model.

Last year the Department of Health released a report on the emergency medical services in Saskatchewan outlining 17 recommendations to enhance the emergency medical system, resulting in an additional $30 million to be spent on emergency services. Mr. Fyke references the EMS (emergency medical services) report in his recommendations and only goes so far as to suggest that improvements to emergency services including centralized dispatch, higher standards for training, and standardization of fees would need to occur. The commission report does not include 24-hour outpatient emergency services as part of the primary health centre model. Based on this assumption, Mr. Fyke seems to imply that enhancements made to the current emergency system would allow for ambulance services to become the emergency rooms in rural Saskatchewan. This is unacceptable and is deemed to create the notion of second-class citizenship for rural Saskatchewan where health care is concerned.

The EMS report pointed out that average ambulance response times in urban Saskatchewan is 7 minutes and 59 seconds. In rural Saskatchewan, the target is one-half hour with a substantially longer travel time for intervention.

Rural residents are not interested in hearing that they will have to travel farther and longer to obtain basic diagnostic services, as well as endure lengthened response times in the event of an emergency.

In regards to local physician practices, continuity of care becomes an issue for the family physician if they cannot follow through on all aspects of patient care including acute episodes. It would be difficult to maintain physician practices in rural communities if there are no acute care services in those communities.

Throughout this report there tends to be an implied expectation that as acute care facilities are converted into primary health centres or community care centres, the surplus of rural health care workers/service providers will seek employment where the jobs are — for example, at a regional acute care centre or the tertiary centres in the urban communities.

It is clear from the discussions we held with our physicians and our service providers that this is a faulty assumption and that retention and recruitment issues could become a larger problem for the urban centres.

In redefining district boundaries, the issue for our service providers and residents is not one of a defined geographic area, but rather the effect amalgamation will have on the programs and services that are currently being delivered in our district. While some people accept that some district reconfiguration is inevitable, there is no support for the district models proposed by Mr. Fyke in his report, noting that he does not take into consideration things like natural travel and service patterns. A lack of decision-making ability at the local level was also identified as being an issue if districts were to become too large. Bigger is not always better.

To summarize, the residents and service providers of the Gabriel Springs Health District believe that these recommendations taken in their purest form would exact a huge cost on rural Saskatchewan that would result in the provision of an inequitable health care system in the province.

There is recognition that some change needs to occur, coupled together with the caution that new infrastructure needs to be in place before the changes are made.

Finally, a challenge has been given to us all that any changes being contemplated will be able to demonstrate a cost benefit and be based on improving the health status of the residents in Saskatchewan.

**The Chair**: — Thank you.

**Mr. Gantefoer**: — Thank you very much, Madam Chair, and thank you for coming, Kelly and Gren.

You make a number of points in regard to the impact of the implementation of Fyke's report, particularly in your health district which is largely rural. And I won't go into all the different areas, but you certainly talk about the issue of physician practice and those sorts of things. You have seven physicians working in the two communities, Rosthern and Wakaw, I understand.

Would there end up being, in the event that Fyke was implemented, a likelihood that you would have a difficult time retaining those seven physicians?

**Ms. Block**: — Based on the discussions that we've held with our physicians, that is exactly what they would indicate. That without the ability to, to provide acute care to the residents in our district, they would not likely stay within the area.

**Mr. Gantefoer**: — So the patient load that those seven physicians are currently meeting would largely gravitate — I guess primarily probably in your district — to Saskatoon, maybe somewhat to Prince Albert at the north end. That would create a significant amount of pressure on those two urban centres then to cope with that workload that is currently being provided by those seven physicians, would it not?

**Ms. Block**: — Yes, it would.

**Mr. Gantefoer**: — You also make the point in saying that if this was implemented in its purest sense that it would exact a huge cost on rural Saskatchewan for a number of reasons. But I'm glad that you approached it strictly from health care

delivery rather than getting into the economics or the other issues although they are definitely there.

And you make the point, I think quite correctly, that before any of these things happen there better be a plan for a new infrastructure put in place that demonstrates a better system before we start throwing out what we've got. Is that fair?

**Ms. Block**: — Yes, that's fair.

**Mr. Gantefoer**: — Are there any other models you looked at? The folks from Craik talked about an Australian model. I wonder if Mr. Smith-Windsor in his capacity as a CEO has got any information or any experience with other models in Australia, or South Africa — we've heard from presenters in the past — that may be useful in this discussion.

**Mr. Smith-Windsor**: — We've restricted, the board has restricted, its remarks to the Fyke report. We really haven't set out to define alternative systems that might be there.

I think it's fair to say, since the beginning of health reform, that the district has bought into the model of wellness, that it has supported an expansion of health promotion and education activities, that it has encouraged a shift between institutional care and community-based services. And the district is quite committed to those issues.

**Mr. Gantefoer**: — And finally in the two major communities where your seven physicians practise, is there any or some collaboration between those two physician centres in terms of collaborative practice, doing locums or on call or things of that nature?

**Mr. Smith-Windsor**: — Absolutely. We have a very active medical advisory committee. Both physicians in both communities meet together regularly and practise collaboratively. There's backup support services for emergency function, surgical services, and obstetrical practices.

**Mr. Gantefoer**: — Thank you.

**The Chair**: — Thank you. Dr. Melenchuk.

**Hon. Mr. Melenchuk**: — Sure. Thank you very much for your presentation. Just one question with regard to diagnostic capabilities. In terms of a primary health and community centre and the suggestion that they wouldn't be able to provide diagnostic services, in your current situation what would you see as being the basic inventory to provide some acute care services and 24-hour emergency response?

**Mr. Smith-Windsor**: — We have presently fundamental X-ray machines in both Wakaw and Rosthern hospitals. Those are of course used in standard examinations including emergencies, where one might question a broken bone, for example. We do not have sophisticated MRIs (magnetic resonance imaging) or CT (computerized tomography) scans, nor is anybody suggesting that we ought to.

In terms of diagnostic services for laboratory, again those would be standard, basic-type practices. The higher end type diagnostic services in terms of laboratory, hematology, and cytology and the like would go into the cities.

**Hon. Mr. Melenchuk**: — Okay. Thank you very much.

**Hon. Mr. Belanger**: — Yes, a question. When we talk about accessibility, I just wanted to ask the question. In northern Saskatchewan there's about 125,000 square kilometres, like we service 35,000 people, and accessibility is probably a more acute problem in the North, primarily because you have some communities that are 75 miles south of the Territories border. And during the winter months, if you're lucky, you get a flight in there because of the weather, and then you're looking at a three- or four-hour wait for someone that's critically ill.

So thank goodness that we have air ambulance services. Because without that, we would be in dire straits in northern Saskatchewan.

That being said, my question is something similar to Mr. Melenchuk's question. In terms of having a good ambulance system in place and to be able to respond in a timely fashion, how do you see a new system developing to bridge that gap between the North, rural, and urban in terms of having a response team in place? What are some of the ideas that you have?

**Mr. Smith-Windsor**: — Could you elaborate? Did you say between the North and urban Saskatchewan?

**Hon. Mr. Belanger**: — No, the North, rural and urban.

**Mr. Smith-Windsor**: — North rural and urban.

**Hon. Mr. Belanger**: — Because obviously there's little gaps in servicing the people. And I'm just wondering, what ideas do you have that would lessen the time constraints that we're faced as a result of some of the facilities being primarily in larger centres or being in the urban settings?

**Mr. Smith-Windsor**: — The issue of emergency services in northern Saskatchewan is truly unique. There are some centres in the southern part of our province, in the Southwest, that share some of those issues in terms of geographic distances, as far as population.

The scope of practice for workers in the health stations in the North have been modified or expanded to include . . . for example, ACNs (advanced clinical nurse) there. The scope of practice is substantially broader than an ACN in southern Saskatchewan would be.

So if we could deal with the northern issues as a unique set, then really what we're left with is rural and urban.

The emergency services report that was published last fall suggested a major restructuring. And the conclusion of our district, after reviewing the report, was we really didn't believe that we needed to abandon and throw out the existing emergency ambulance system.

We do believe that there are some structural issues that need to be addressed. In the existing ambulance service that serves our areas those include: one, wage parity for ambulance workers so

that we can attract and retain skilled workers. We would like to improve our service from an EMT (emergency medical technician) service to an EMTA (emergency medical technician advanced) advanced service. I don't think Mr. Fyke would oppose that. We would like to see that improvement made.

There are some funding issues having to do with the ambulance infrastructure, specifically fleets and capital replacement. There is not a capital replacement plan that I know of operational in the province.

In the cities, most rural residents would really envy the kind of service that — emergency ambulance service — that is in the cities. The response time as seven minutes and fifty-nine seconds listed in the report is not only much faster than rural Saskatchewan but it's also by and large a paramedic service and the scope of practice for paramedics is much, much broader than either an EMTA or an EMT.

We don't know whether we could support, in terms of volumes of service, the kind of skill maintenance required for paramedics, but we think that an EMTA qualification would vastly improve our district and other rural districts.

**The Chair**: — I see no more questions. Thank you very much for your presentation.

And I'll now entertain a motion to adjourn. Moved. And we will stand adjourned till 10:30 tomorrow morning.

The committee adjourned at 12:10.